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Low self-esteem

Low self-esteem has been described as a negative image of the self, which tends to be global, persistent and enduring (Fennell, 1997). Low self-esteem has been associated with many mental health difficulties, although the nature of the relationship is unclear. Some suggest mental health problems lower self-esteem (Ingham, Kreitman et al., 1987) whilst others suggest low self-esteem predisposes to mental health difficulties (Wilhelm, Parker et al., 1999). Fennell (1997) proposed a cognitive-behavioural (CBT) model of low self-esteem, which suggests negative life experiences lead to the development of the “bottom line”, a negative self-belief reflecting sense of worth. Research has shown attachment to parents is directly related to self-esteem (Laible, Carlo, & Roesch, 2004). This is consistent with the assumptions of attachment theory which suggests secure attachments with parents are important for the development of healthy models of the self (e.g. Allen & Land, 1999). Research has also demonstrated a link between childhood adversity and the later development of Emotionally Unstable Personality Disorder (EUPD) (Ball & Links, 2009), where low self-esteem and negative view of the self are core features (Lynium, Wilberg & Karterud, 2008). Such research highlights the importance of considering an individual’s attachment style and early life experiences when understanding an individual’s presentation of low self-esteem. According to the CBT model of self-esteem, specific situations can trigger this bottom line which leads to negative automatic thoughts (NATs) about the self, behaviours and emotions, which in turn confirm the bottom line. This model suggests people with low self-esteem will process incoming information in line with their negative view of themselves; underestimating their strengths and overemphasising their weaknesses (Fennell, 1997).

CBT for low self-esteem aims to reduce negative sense of self, increase awareness of positive qualities and engagement in enjoyable activities (Fennell, 2006). Intervention tends to involve monitoring and modifying NATs, working with self-criticism to cultivate self-esteem, and working with dysfunctional assumptions and the bottom line. To date there is limited evidence regarding the effectiveness of CBT for low self-esteem in the general population. Waite, McManus and Shafran (2012) conducted a preliminary RCT in a primary care setting using Fennell's (1997) model focused on low self-esteem and found participants who received the intervention showed significant improvements on measures of low self-esteem, overall functioning, and depression.

CBT for low self-esteem in people with learning disabilities

Adapted forms of CBT have been used with people with learning disabilities for a range of difficulties (British Psychological Society, 2015) and it can be an effective psychological approach for this client group (e.g. McCabe, McGillivray, & Newton, 2006; Sturmey, 2004). CBT should be adapted to the person with learning disabilities' level of understanding, strengths and needs, taking into account physical, neurological, cognitive or sensory impairments and communication needs (British Psychological Society, 2015). Therapists may need to be more didactic when working with people with learning disabilities and present key concepts in concrete forms. Visual aids can be effective and therapy may need to be at a slower pace, using repetition (Hassiotis, Serfaty et al., 2012).

Previous studies have shown low self-esteem is common in people who have a learning disability (Dagnan & Waring, 2004). Stigmatisation, repeated episodes of failure, unemployment, and fewer opportunities for friendships and relationships are frequently

experienced by people with learning disabilities (Caine and Hatton, 1998) and there are still prevalent negative societal views that people with learning disabilities do not contribute to the economy. The impact of negative social comparisons on people with learning disabilities' sense of self has been well documented (Paterson, McKenzie, & Lindsay, 2012). Goldberg et al (1995) proposed people with learning disabilities may progress differently through the family life cycle, for instance living at home with parents for longer, and an awareness of this difference in comparison to others may affect self-beliefs. It is not surprising such experiences may contribute to the development and maintenance of low self-esteem and it is important to take into account the significant differences in societal experiences of people with a learning disability in comparison to those who do not have a learning disability.

There is currently a paucity of research examining CBT for low self-esteem in people with learning disabilities, with only two published studies in this area. Whelan, Haywood and Galloway (2007) ran a self-esteem CBT group for adults with learning disabilities and found some positive changes in participants' self-esteem levels. Similarly, Bishop and Henry (2008) found observable positive behaviour changes with a man with mild learning disabilities and a history of violent behaviour. This limited research indicates an adapted version of the cognitive model of low self-esteem may be of benefit to people with learning disabilities but further research is needed.

Emotion regulation difficulties in people with learning disabilities

Research suggests a third of adults with learning disabilities have difficulties with emotion regulation and display behaviours that challenge (Brown, Brown et al., 2013). Such difficulties may be due to reduced opportunities within society for people with learning disabilities to learn to express and manage their emotions. It is proposed emotion regulation skills deficits can contribute to behaviours that challenge in this client group (Tyrer, 2006) and it is therefore important potential deficits in emotion regulation are not ignored when working with people with learning disabilities. Aspects of dialectical behaviour therapy (DBT) focus on developing an individual's ability to regulate their emotions, including teaching distress tolerance skills and practicing mindfulness exercises. DBT has been shown to be effective in other client groups who struggle to manage their emotions (e.g. Linehan et al., 2006). There is evidence demonstrating the effectiveness of mindfulness for people with learning disabilities, particularly the soles of the feet exercise (Singh, Wahler et al., 2003) and there is emerging evidence illustrating a positive impact for people with learning disabilities following engagement in DBT (e.g. Brown, Brown & Dibiasio, 2013).

This case study describes the use of an adapted form of CBT focused on low self-esteem for a person with a learning disability who had difficulties in managing their emotions and aims to add to the currently limited evidence base in this area.

Referral details

Sarah was a 42 year old white British female from a low socio-economic background who was referred to clinical psychology within the community learning disabilities team by her GP. The referral was initially to focus on difficulties Sarah had in regulating her emotions.

Assessment and history

To make the assessment process more accessible, activities such as a timeline and circle of support were used. Sarah lived in supported living accommodation with two other service users. She had three hours of staff support per day. Sarah had a diagnosis of a mild learning disability, mixed anxiety and depressive disorder and EUPD.

Initially, Sarah said she would like to have support with 'managing her anger'. When feeling angry, Sarah said she would shout, scream, kick doors, say negative comments towards others and hit her legs. She would also talk negatively about herself out loud, for example calling herself 'ugly', 'fat', and wishing she could 'wash her face away'. Sarah said she'd thought negatively about herself throughout her life and viewed herself as 'different' because of her mental health diagnoses. She would often compare herself to others, begin to talk negatively about herself and this would lead her to feel upset and angry. The content of Sarah's negative self-talk seemed to reflect her previously traumatic experiences of bullying.

Sarah participated in very few activities. She occasionally engaged in household chores but often struggled with motivation to do these activities. Sarah talked of how, when she was at home and was bored, she would often start to talk in a self-critical way. It was hypothesised

Sarah's low self-esteem impacted on her motivation to engage in activities as she thought she was not able to do activities well and so she did not begin activities.

Sarah enjoyed visiting her parents who she saw once a month. Sarah had an older brother and sister who she did not have contact with. Sarah talked of a difficult relationship with her brother, who was verbally abusive towards her about her learning disability.

Sarah had attended a mainstream primary school, where she'd made many friends and she had really enjoyed school. Sarah then attended a special educational needs school between the ages of 11 and 16. Sarah described this as a very difficult experience and is an example of her progressing differently through the life cycle (Goldberg, 1995) in comparison to her peers and siblings. She recalled feeling 'different' to the other students as she had a mild learning disability and felt her needs were primarily related to her difficulties in managing her emotions whilst many of the other students had more significant learning disabilities. She was bullied by other pupils and felt this was because she was different to them. At age 16 Sarah moved from home to a residential house, where she reports she was sexually assaulted by another resident. This was investigated by the police but a conviction was not made. Sarah said she did not want to talk about this experience. Sarah had also previously reported that she'd experienced sexual abuse by her grandfather at aged 8. She attended counselling following this but there was no police investigation.

Sarah described a history of difficulties in managing her emotions. She had experienced a number of placement breakdowns throughout her life due to placements struggling to manage her behaviour. Sarah did not have any suicidal thoughts or ideation.

Through collaborative discussion, the therapist and Sarah identified how Sarah's negative self-talk would often lead her to feel angry with herself. Although Sarah had a diagnosis of EUPD, her negative view of herself was very distressing and so it was agreed low self-esteem and emotion regulation would be the focus of the sessions. Sarah and the therapist met for 15 sessions. During the assessment the nature of CBT was explained to Sarah in an accessible way, including expectations such as homework and session length, and she was very keen to engage. Sarah requested her support worker attended sessions with her. This was helpful for staff supporting Sarah to practice interventions in between sessions. Sarah was fully informed the author was a trainee clinical psychologist on placement. Sarah consented for this case study to be written and submitted for publication.

Goals

The following goals were defined for treatment:

- To develop Sarah's ability to regulate her emotions; with the aim of reducing her feelings of anger from 8/10 to 4/10 (where 1 refers to not angry at all and 10 refers to feeling very angry all of the time) and to reduce the frequency of these feelings of anger.
- To increase Sarah's self-esteem and reduce the frequency of her negative self-talk.

Formulation

Through discussion, Sarah and the therapist collaboratively developed a hypothesis of how Sarah's difficulties had developed and possible maintaining factors. An adapted version of Fennell's (1997) CBT model of low self-esteem was used because Sarah's negative view of herself often seemed to lead to angry feelings and behaviours.

Fennell (1997) suggests negative experiences can lead to the development of global negative beliefs about the self, known as the 'bottom line'. Sarah progressed differently through the family life cycle (Goldberg et al, 1995) in comparison to her siblings who were high achievers and went to University. Moving to a special educational needs school may have highlighted to Sarah the differences between her and her siblings and friends from mainstream school. It was hypothesised this awareness of difference and her difficult life experiences, such as bullying and sexual abuse, may have led Sarah to develop a bottom line of 'I'm different because of my learning disability and mental health difficulties and I'm not good enough'. Sarah had experienced a number of placement breakdowns, suggesting Sarah had experienced many losses and changes in physical environment, routines, relationships ending etc. These experiences could have been interpreted as rejection and reinforced her bottom line of 'I'm different and I'm not good enough'.

It was proposed Sarah's frequent comparisons to other people and her awareness of difference was contributing to Sarah's low self-esteem and triggered negative self-talk.

These comparisons were likely to occur when Sarah was bored and not engaging in an activity or when demands were placed on Sarah to do a task which she struggled to do.

When in these situations Sarah would start to have self-critical thoughts about herself, such as 'I'm fat and ugly', 'I'm a stupid cow', and she would say these thoughts out loud. When

she did this, Sarah noticed she would feel tense, had a 'knot in her stomach' and she felt sad and angry. When she felt sad and angry, Sarah would then shout, say negative comments about other people, hit her legs and kick her bedroom door. It was hypothesised these behaviours increased Sarah's negative self-critical thoughts and reinforced her bottom line that she is 'different and not good enough'.

Given Sarah's past history of abuse and bullying, it could be hypothesised Sarah had learnt she needed to protect herself from others and becoming angry when her self-esteem was threatened was a way to protect herself. High levels of arousal and sensitivity to threat have been found in people who have experienced childhood abuse (Penza, Heim et al., 2003), which could suggest Sarah may be more likely to be anxious and on alert for potential threats.

Sarah had few meaningful, reciprocal relationships in her life. It is proposed a sense of self is maintained through feedback from important others (Fiske and Taylor, 1991) and therefore the absence of such figures in Sarah's life may have been contributing to her poor self-image.

Based on the formulation and Sarah's goals of therapy it was hypothesised, through the use of CBT focused on low self-esteem, Sarah's self-esteem would improve and this would lead to improved emotion regulation and reduce Sarah's feelings of anger. The following hypotheses were developed:

- By reducing the frequency of Sarah's negative self-talk and cultivating her self-esteem, Sarah's feeling of anger will reduce and her self-esteem will increase.

- By increasing Sarah's engagement in enjoyable activities, her self-esteem will increase.

Outcome measures

- Idiographic ratings of angry feelings on a scale of 1-10 (where 1 represents not angry at all and 10 represents very angry all of the time) were taken on a regular basis, using a visual scale with 'angry', 'ok', and 'happy' faces accompanying the numbers to make the scale more accessible. It would have been desirable to use a standardised scale to measure anger. Idiographic ratings were used as Sarah did not want to complete extra measures in addition to those described below and idiographic ratings could be given quickly.
- The adapted version of the Rosenberg Self-Esteem Scale for people with a learning disability (Dagnan and Sandhu, 1999) was used on a regular basis to measure self-esteem. This is a six-item self-report scale, where the participant rates how true each item is, using a five-point visual analogue scale (with options ranging from never true to always true). Responses for each item are assigned a score from 1 to 5 and a higher score represents a greater level of self-esteem. This scale has been shown to have adequate internal consistency (Cronbach's alpha coefficient of 0.66).
- Adapted versions of the Generalised Anxiety Disorder Assessment (GAD-7; Spitzer, Kroenke, Williams & Löwe, 2006) and the Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) were used to assess anxiety and depression symptoms at the start, midway and end of therapy. Although there is limited evidence on the validity of these measures for people with learning disabilities, these measures were used as there are not currently robust standardised measures

of anxiety and depression for this client group. Furthermore, the IAPT Learning Disabilities Positive Practice Guide (Dagnan, Burke, Davies & Chinn, 2015) suggests measures such as the GAD-7 and PHQ-9 are likely to be accessible for people with learning disabilities if delivered sensitively.

Intervention

The intervention included a number of cognitive and behavioural techniques as discussed below:

Psychoeducation: Time was spent validating Sarah's difficult life experiences and providing psychoeducation around the cognitive model as a way of helping Sarah to understand her current difficulties. This included producing a vicious circle of the hypothesised relationship between Sarah's negative thoughts, low mood, physical sensations and behaviours. This seemed to help Sarah to identify the early warning signs of anxiety, which was important for utilising distress tolerance strategies.

Mindfulness and distress tolerance strategies: Mindfulness and distress tolerance are aspects of DBT which can aid emotion regulation and so they were incorporated into the intervention. Time was spent explaining the concept of mindfulness to Sarah and practicing several accessible, concrete mindfulness exercises within sessions. This included: mindfulness using objects (such as shells and marbles), mindful colouring and 'mindfulness on the soles of the feet' (Singh, Wahler et al., 2003). Sarah then practiced these exercises in between sessions when calm and when she noticed her self-critical thoughts. Other distress

tolerance strategies were also practiced including deep breathing relaxation exercises and distraction activities such as listening to music.

Cultivating positive self-esteem: A key aim of CBT for low self-esteem is to reduce the person's negative sense of self and increase awareness of positive qualities (Fennell, 1997). It was hypothesised Sarah's self-critical thoughts led Sarah to feel sad and angry and to display behaviours such as slapping her legs. To try and reduce this self-critical thinking, and in turn reduce Sarah's feelings of anger and sadness, Sarah kept a diary of the content of her negative self-talk. The therapist and Sarah then attempted to challenge these thoughts and generate kinder alternatives. Sarah struggled to do this and so instead chose to say the phrase 'I am a good person' each time she noticed she was talking negatively about herself. Sarah made a poster of this to keep on her bedroom wall as a reminder. To increase Sarah's awareness of critical and kinder self-talk, a game which involved matching self-critical statements to kinder statements about the self was used. Time was also spent in session producing a 'gallery of assets' of Sarah's positive qualities. Sarah reflected on how this helped her to feel good about herself as she normally focused on the things she didn't like about herself. Sarah tried to write down one positive quality about herself each day for homework and noticed she felt better about herself after doing so.

Activity scheduling: Sarah participated in few activities and boredom seemed to be a trigger for her negative self-talk. Lewinsohn's (1974) behavioural theory suggests increasing activities which give pleasure and mastery may improve mood. Moreover, one of the aims

of CBT for low self-esteem (Fennell, 1997) is to increase engagement in enjoyable activities. Therefore, time was spent in session identifying activities which may give Sarah a sense of pleasure and/or mastery. Sarah then planned these activities into her day and noticed a positive impact on her mood following engagement in these activities.

Working with the bottom line: It was hypothesised Sarah's bottom line was 'I'm different because of my learning disability and mental health difficulties and not good enough'. Collaboratively developing the formulation with Sarah helped her to understand how this bottom line may have developed from past experiences. Through discussions, Sarah and the therapist were able to identify instances of thought biases which Sarah often took as evidence for the bottom line. For example, Sarah had applied for a job shortly before beginning therapy and hadn't heard anything after submitting her application form. Sarah said she knew this was because of her mental health difficulties. By looking for evidence for and against this rationale, Sarah was able to see how she may have jumped to a conclusion in this situation and possible alternative explanations were generated. This then gave Sarah the confidence to apply for and get a voluntary job. Furthermore, cultivating Sarah's positive self-esteem, as described above, provided evidence for an alternative bottom line of 'I'm different because I have a learning disability and mental health problems but there are also things I am good at'.

Although the main focus of the interventions were at an individual level, a number of interventions with wider systems in Sarah's life were utilised. This included: sharing the formulation with Sarah's support team to increase their understanding of Sarah's difficulties; sharing ideas for support strategies which may be helpful for Sarah with her

staff; and writing a letter for Sarah to share with future employers outlining ways in which they could support her at work.

Assessment measures

As figure 1 shows, although there were some fluctuations in her ratings, overall Sarah's idiographic ratings of her feelings of anger decreased gradually over time. By the end of therapy Sarah's anger rating was 4/10, which was one of Sarah's goals.

As figure 2 shows, there was a gradual increase in Sarah's self-esteem over time. There was however a noticeable drop in her self-esteem score during session 13. At this time, Sarah's support worker, who had worked with her for several years, had left her job and her other support worker was also off work due to illness. Sarah found these changes really difficult and this may have contributed to the drop in her self-esteem.

There was not a significant difference in Sarah's anxiety and depression symptoms over time; with her anxiety symptoms increasing by one point and her depression symptoms reducing by 1 point during therapy. Previous research in the general population using CBT focused on low self-esteem has found a reduction in anxiety and depression symptoms (e.g. Rigby & Waite, 2006) and so the reasons for the lack of change in these measures is unclear.

Outcome and discussion

Overall, the outcome measures showed a reduction in Sarah's feelings of anger, reducing from 8/10 in session 1 to 4/10 in session 15. There was also an increase in Sarah's self-

esteem, as measured by the adapted Rosenberg self-esteem scale. This case study could therefore make a small contribution to the evidence base for the effectiveness of CBT-based treatments for low self-esteem in people with learning disabilities; an under-researched area.

The main focus of this intervention was on Sarah's low self-esteem alongside distress tolerance strategies for managing her emotions as it was hypothesised this would have the biggest impact on Sarah's quality of life. The outcome measures indicate this was an effective intervention. This suggests a careful assessment is required in order to formulate an individual's difficulties and to choose an appropriate intervention. As Sarah had difficulties in managing her emotions and had initially expressed she wanted help in 'managing her anger', Dialectical Behaviour Therapy may have been an alternative approach. This approach would not have focused in detail on Sarah's low self-esteem, which seemed to be contributing to her distressing emotions.

It was hypothesised Sarah had an insecure attachment style and the loss or absence of meaningful relationships contributed to Sarah's low self-esteem. Sarah and the therapist developed a good therapeutic relationship, which may have in turn had a positive impact on her self-esteem, thus potentially influencing therapy outcomes. If Sarah had been offered a less relationally involved intervention, such as computerised CBT, it is unlikely there would have been similar outcomes as Sarah relied heavily on the support of the therapist.

There were a number of adaptations made to therapy based on Sarah's individual needs. Such adaptations are supported by BPS recommendations for conducting psychological interventions with people with learning disabilities (British Psychological Society, 2016). For example, Sarah often reported she would forget to use the distress tolerance techniques

when she became very anxious. To try and overcome this, Sarah and the therapist made a prompt sheet of distress tolerance techniques for Sarah's bedroom wall. Key concepts were also frequently repeated to aid Sarah's memory. Sarah's staff member also had a significant role in supporting Sarah outside of the sessions. Her staff member would remind her to complete her homework, prompt her on a daily basis to practice mindfulness and help Sarah to think about her positive qualities. Sarah also struggled with cognitive aspects of the intervention, such as generating alternatives to self-critical thoughts. This may have been more difficult because of her learning disability and creative ways of introducing alternatives were used, such as matching self-critical statements to kinder statements, highlighting the importance of adapting cognitive aspects of CBT when working with people with learning disabilities. Visual aids were often used alongside verbal discussions to facilitate engagement and understanding.

Limitations

Towards the end of therapy Sarah's support worker left her job and her other support worker was off work for a number of weeks. Sarah found this really difficult, which may relate to Sarah's hypothesised insecure attachment style, and she struggled to implement some of the intervention strategies, which seems to be reflected in the outcome measures. This could not be predicted at the beginning of therapy but highlights the importance of a stable home environment during therapy to help to maximise therapy outcomes. The case study highlighted the importance of involving the client's network so support with intervention strategies could continue after therapy. Sarah had a very limited support package and so staff were not always present to support her in implementing strategies. Furthermore, the member of staff who had supported Sarah at each session left her job

towards the end of therapy, meaning the staff member's knowledge of strategies would not continue to be shared with other staff members. In hindsight, it would have been desirable to involve more of the wider network, e.g. sharing information in a network meeting, so support with intervention strategies was more likely to continue following therapy.

It would have been desirable to collect follow-up measures to see whether the changes in Sarah's feelings of anger and self-esteem remained following intervention. Furthermore, the validity of the PHQ-9 and GAD-7 with people with learning disabilities has not been well evidenced. It is also important to note the limitations of self-report measures. For example, Sarah may have felt pressure to rate her anger as lower towards the end of therapy as she knew the sessions were coming to an end.

As the intervention also included distress tolerance techniques, the use of such strategies may have impacted on the findings and therefore may limit the conclusions that can be drawn about the impact of CBT focused on low self-esteem. There is a need for larger trials looking at the use of CBT focused on low self-esteem for people with learning disabilities to further assess whether this is an effective intervention for this client group.

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